**U.S. Department of Labor**

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**Issue date: 05Aug2002**

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| ***In the Matter of:*** | : | |
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| DENNIS BLANKENSHIP, | : | Case No: 1999-BLA-1216 |
| Claimant, | : | |
| | : | |
| v. | : | |
| | : | |
| CANNELTON INDUSTRIES, INC., | : | |
| Employer, | : | |
| | : | |
| and | : | |
| | : | |
| DIRECTOR, OFFICE OF WORKERS' | : | |
| COMPENSATION PROGRAMS, | : | |
| Party-in-Interest | : | |

Frederick K. Muth, Esquire
For the Claimant

Mary Rich Maloy, Esquire
For the Employer

Before: EDWARD TERHUNE MILLER
Administrative Law Judge

**DECISION AND ORDER ON REMAND - AWARDING BENEFITS**

Statement of the Case

This case was remanded to this tribunal by unpublished decision and order of the Benefits Review Board (the "Board") dated September 26, 2001, affirming in part and vacating in part this tribunal's July 20, 2000 award of benefits based on its finding that the evidence established the existence of complicated pneumoconiosis, and, therefore, that the Claimant was entitled to invocation of the irrebuttable presumption of total disability due to pneumoconiosis. On remand, the Board instructed this tribunal to further consider this case consistent with its opinion.[1]

[1]The Board's decision and order was issued on September 26, 2001, and this tribunal has not received briefs on remand or a request for a briefing schedule from either party, despite the Board's suggestion in its

Specifically, the Board instructed this tribunal to consider all of the evidence of record, to determine what evidence was submitted with Employer's Exhibits 10 and 11, to determine whether the interpretations of the October 13, 1999 x-ray film are part of the evidentiary record, as alleged by Employer, to consider the physicians' credentials in analyzing the medical evidence of record, to reweigh each medical opinion without considering the physicians' findings as to the existence of a pulmonary impairment, and, if on remand, this tribunal again awards benefits, to render appropriate findings with regard to the issue of the date of onset for entitlement. The Board affirmed this tribunal's attribution of less weight to the opinions of those physicians who did not diagnose simple coal workers' pneumoconiosis because they were based on an incorrect underlying premise, the absence of simple coal workers' pneumoconiosis.

This proceeding involves a duplicate claim for benefits under the Black Lung Benefits Act as amended, 30 U.S.C. §§ 901 *et seq.* ("the Act"), and the regulations promulgated thereunder.[2, 3] Since this claim was filed after March 31, 1980, Part 718 applies. Because the Claimant was last employed in the coal industry in West Virginia, the law of the Fourth Circuit of the United States controls. *See Shupe v. Director, OWCP*, 12 BLR 1-200, 1-202 (1989)(*en banc*).

## Issue[4]

The sole issue presented for resolution is whether Claimant has established that he has complicated pneumoconiosis. If so, he has also established a material change in conditions since the denial of his previous claim for benefits, as he will have shown total disability through invocation of the irrebuttable presumption of total disability due to pneumoconiosis. §§725.309(d) (pre-amended pursuant to §725.2), 718.304. (Tr. 6-8; D-35).

## Findings of Fact and Conclusions of Law

*Background*

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Decision and Order.

[2]All applicable regulations which are cited are included in Title 20, Code of Federal Regulations, unless otherwise indicated, and are cited by part or section only. Director's Exhibits are denoted "D-"; Claimant's Exhibits are denoted "C-"; Employer's Exhibits are denoted "E-"; and citations to the hearing transcript are denoted "Tr."

[3]Claimant's last claims were denied in 1986 and 1988 for failure to establish total disability. (D-32, 33).

[4]At the hearing, Claimant conceded that total disability is not established by any of the means under §718.204(c) (pre-amended), and that his claim rests upon a showing of complicated pneumoconiosis.

Claimant, Dennis Blankenship, was seventy-four years old at the time of the hearing before this tribunal on December 1, 1999. For purposes of augmentation of benefits under the Act, Claimant has a dependent child, a grandson whom he legally adopted (D-1, 10, 11; Tr. 16-17). Claimant's last employer was the named Employer, Cannelton Industries, Inc., for whom he last worked as an end load operator, truck driver, and loader (D-2, 7; Tr. 19-21). Employer conceded at the hearing that it is the responsible operator, that Claimant was a coal miner for twenty-six years, and that he has simple coal workers' pneumoconiosis which arose from that employment (Tr. 7).

*Medical Evidence Related to the Issue of Complicated Pneumoconiosis*[5]

*X-ray Evidence*

| **Exh. No.** | **Date of X-ray** | **Date of Reading** | **Physician/ Qualifications** | **Interpretation** |
|---|---|---|---|---|
| C-1 | 2/28/94 | 2/28/94 | Aycoth B | Diffuse reticulonodular fibrosis believed to represent coal workers' pneumoconiosis in association with at least two ill defined foci of increased markings also probably superimposed chest wall pleural thickening. |
| E-10 | 2/28/94 | 2/2/00 | Wheeler B/R | 0/0; subtle focal infiltrates or fibrosis in lateral periphery upper lobes with tiny linear scar in lateral subapical portion RUL compatible with inflammatory disease. |
| E-11 | 2/28/94 | 2/2/00 | Scott B/R | 0/0; peripheral infiltrates and/or fibrosis lateral portion both upper lungs. Distribution is not compatible with silicosis/CWP |
| E-12 | 2/28/94 | | Kim B/R | 0/0; TB; infiltrates or fibrosis in the periphery of upper lung bilat prob. granulomatous process, unknown activity |

[5] The following abbreviations are used in describing the qualifications of the physicians: B-reader, "B"; board-certified radiologist, "R". An interpretation of "0/0"signifies that the film was read completely negative for pneumoconiosis. The credentials of Drs. Ahmed, Miller, and Gaziano are not of record. However, this tribunal takes judicial notice that their relevant qualifications are disclosed on the worldwide web, American Board of Medical Specialties, Who's Certified Results, at http://www.abms.org. This tribunal also take judicial notice that Drs. Aycoth, Ahmed, Miller, and Pathak are listed as B-readers on the list of NIOSH Approved Readers. *See Maddaleni v. Pittsburgh & Midway Coal Mining Co.*, 14 BLR 1-135 (1990). Dr. Aycoth's and Dr. Pathak's professional credentials other than their status as a B-readers are not of record and could not be ascertained.

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| C-1 | 6/9/94 | 6/10/94 | Ahmed B/R | Mild underlying COPD and pneumoconiosis. No pneumonia or congestive failure. Focal mass representing neoplasm is not appreciated. |
| C-1 | 10/14/98 | 10/15/98 | Miller B/R | Findings consistent with pneumoconiosis with slight worsening compared to 1994. |
| D-15 | 12/9/98 | 1/15/99 | McFarland B/R | 2/3, p/s, Category A large opacity; coalescence |
| D-16 | 12/9/98 | 12/9/98 | Gaziano B | 2/1, p/q, Category A large opacity; upper lobe lesion complicated CWP rule out cancer |
| D-24 | 12/9/98 | 3/29/99 | Castle B | 2/2, q/q; coalescence; TB; granulomatous drop both apices |
| E-4 | 12/9/98 | 10/12/99 | Castle B | 2/2, q/p; coalescence; calcified granulomatous apices and upper lobes |
| D-25 | 12/9/98 | 5/4/99 | Scott B/R | 0/1, p/q; TB; peripheral upper lung infiltrates compatible with TB, unknown activity |
| D-25 | 12/9/98 | 5/5/99 | Wheeler B/R | 0/1, t/q; TB; patchy infiltrates RUL>LUL and left apex compatible with TB unknown activity, probably healed; few small nodules in this case could be pneumoconiosis but TB often has asymmetry and apical disease |
| D-26 | 12/9/98 | 5/14/99 | Kim B/R | 0/1, p/q; bilateral upper lung infiltrates, rt>lt; compatible with granulomatous process, unknown activity |
| E-3 | 12/9/98 | 9/13/99 | Fino B | 1/1, r/r; There was coalescence in the right upper lobe. These changes could be related to tuberculosis. Clinical correlation is necessary. |
| E-4 | 12/9/98 | 9/17/99 | Hippensteel B | 2/3, p/q; coalescence; calcified granulomas in both upper lobes; abnormalities could all be secondary to granulomatous disease rather than CWP |
| C-1 | 2/10/99 | 2/11/99 | Ahmed B/R | COPD with change consistent with complicated pneumoconiosis where seen before. No new infiltrates or nodules in the lung fields. No pneumothorax. |
| C-1 | 3/30/99 | 3/30/99 | Aycoth B | Advanced chronic obstructive pulmonary disease with changes of complicated pneumoconiosis and overall appearance of study the same as previous 2/10/99 examination. |
| D-30 | 6/19/99 | 6/19/99 | Dahhan B | 1/1, r/r; coalescence; right upper zone calcification; questionable TB |

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| D-31 | 6/19/99 | 7/19/99 | Scott B/R | 0/1; t/q; TB; calcified granuloma lateral portion left upper lung; patchy infiltrates upper lungs compatible with TB, quite possibly active |
| D-31 | 6/19/99 | 7/21/99 | Wheeler B/R | 0/1, t/q; TB; coarse infiltrates or fibrosis RUL and lower left apex and small nodules with several calcified granulomata in lateral portion both upper lobes compatible with TB unknown activity, probably healed. Probable calcified granuloma in aortopulmonary angle left hilum; a few small nodules in this case could be pneumoconiosis but granulomatous disease explains all the lung findings |
| C-2 | 6/19/99 | 1/11/00 | Cappiello B/R | Complicated pneumoconiosis with large opacity Category A and small opacities p/q, 2/2; Coalescent opacity left upper lobe. |
| E-1 | 6/19/99 | 8/4/99 | Kim B/R | 0/1; t/q; TB; patchy nodular infiltrates in both upper lobes prob. granulomatous process, unknown activity; Prob. several small granulomatous calcifications in both upper lungs. |
| E-3 | 6/19/99 | 9/13/99 | Fino B | 1/1, r/r; There was coalescence in the right upper lobe. These changes could be related to tuberculosis. Clinical correlation is necessary. |
| E-4 | 6/19/99 | 10/12/99 | Castle B | 2/2, q/p; coalescence; bilateral upper lobe granulomatous disease |
| E-4 | 6/19/99 | 9/17/99 | Hippensteel B | 2/3, p/q; coalescence; calcified granulomas in both upper lobes; abnormalities could all be secondary to granulomatous disease rather than CWP |
| C-1 | 8/5/99 | 8/5/99 | Groten | Right pneumothorax |
| C-1 | 8/5/99 | 8/5/99 | Groten | Chest portable: right pneumothorax |
| C-1 | 8/5/99 | 8/5/99 | Groten | Approximate 20% right sided pneumothorax |
| C-1 | 8/6/99 | 8/6/99 | Groten | Stable right sided pneumothorax |
| C-1 | 8/10/99 | 8/10/99 | Olson | Small right pneumothorax |
| C-1 | 8/13/99 | 8/13/99 | Rahman | Chest portable: right apical pneumothorax |

*CT Scan Evidence*

| **Exh. No.** | **Date of CT Scan** | **Date of Reading** | **Physician/ Qualifications** | **Interpretation** |
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| C-1 | 12/29/98 | 12/30/98 | Pathak B | COPD with extensive changes of pulmonary pneumoconiosis and coarse reticulonodular fibrosis in both upper lobes with changes of early progressive massive fibrosis bilaterally, slightly more pronounced in the right side. No acute intra thoracic process. Nodular densities in both upper lobes are believed to be related to pulmonary pneumoconiosis rather than neoplastic disease. |
| E-10 | 12/29/98 | 2/2/00 | Wheeler B/R | No pneumoconiosis; TB more likely than other granulomatous disease with: focal linear, irregular and small nodular infiltrates in left apex and subapical and lateral portion upper lobes and superior segment LLL/few small calcified granulomata in upper lobes and mediastinal and subcarinal nodes and one in left lower lung near diaphragm dome; scars in upper lobes extend to pleura and cause left apical pleural thickening. |
| E-11 | 12/29/98 | 2/4/00 | Scott B/R | Fibrosis peripheral portion both upper lungs compatible with healed tuberculosis; there is one area of alveolar infiltrate in the right upper lung, so active disease is possible; few slightly enlarged mediastinal lymph nodes, probably post inflammatory |
| C-1 | 8/2/99 | 8/2/99 | Ahmed B/R | Progression in nodules in the upper half of the lung fields, neoplastic progress could be possibility. Focal opacity right suprahilar region. Multiple larger than 1.0 cm. size lymph nodes in the superior mediastinum. If indicated, biopsy under CT could be performed for further evaluation. No effusion |
| E-10 | 8/2/99 | 2/2/00 | Wheeler B/R | 4 cm mass lateral portion RUL and few 1-2 cm masses in subapical portion upper lobes compatible with conglomerate TB with linear and irregular focal infiltrates or fibrosis in upper lobes and few small nodules in superior segment LLL and one in lower lingula all compatible with TB unknown activity, probably healed; disease extends to pleura and causes apical pleural thickening which is more typical of TB than other granulomatous diseases; few tiny calcified granulomata in mediastinal and left hilar nodes from healed TB or possible histoplasmosis |
| E-11 | 8/2/99 | 2/4/00 | Scott B/R | Bilateral, largely peripheral, upper lung fibrosis compatible with healed tuberculosis; one area of alveolar infiltrate or fibrosis or mass right upper lung which could be active inflammatory process. Cancer cannot entirely be excluded; few slightly enlarged mediastinal lymph nodes, probably post-inflammatory |

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| C-2 | 8/2/99 | 12/10/99 | Cappiello B/R | Multiple upper lobe pulmonary nodules in association with mediastinal nodes. Neoplasms cannot be ruled out; however, coalescent pulmonary fibrosis may provide similar appearance. CT biopsy may be considered. |
| E-12 | 8/2/99 | | Kim B/R | Fibronodular infiltrates with a 4x3 cm nodule in the rt upper lobe prob. granulomatous process; small granulomatous calcifications are also seen in mediastinum; minimal pleural thickening is also seen in the left apex |
| E-10 | 8/5/99 | 2/2/00 | Wheeler B/R | Limited to 2 scans of upper lungs showing needle aspiration biopsy of anterior portion; mass is compatible with conglomerate TB and there are nodules and linear scars in upper lobes compatible with TB unknown activity, probably healed |
| E-11 | 8/5/99 | 2/4/00 | Scott B/R | Images during biopsy procedure showing needle tip in right upper lung focal infiltrate/fibrosis/mass |
| E-12 | 8/5/99 | | Kim B/R | Linear and nodular infiltrates in the upper lobes bilateral, more involved rt lung, prob granulomatous process activity unknown; close f/u is advised |

*Minified Digital Images*[6]

| **Exh. No.** | **Image Date** | **Date of Reading** | **Physician/ Qualifications** | **Interpretation** |
|---|---|---|---|---|
| E-10 | 6/9/94 | 2/2/00 | Wheeler B/R | Subtle focal and small nodular infiltrates in lower left apex and lateral periphery upper lobes compatible with granulomatous disease, probably TB; Tiny linear scar in subapical portion RUL |
| E-11 | 6/9/94 | 2/2/00 | Scott B/R | Minimal fibrosis and/or infiltrates periphery of upper lungs unchanged since 28 Feb 1994; the distribution of these changes is not compatible with silicosis/CWP |
| E-12 | 6/9/94 | | Kim B/R | Fibrosis or infiltrates in both upper lungs prob. granulomatous process, activity unknown |

[6]During his February 8, 2000 deposition, Dr. Wheeler, board-certified in radiology and a B-reader, explained that minified digital images are made from chest x-rays. However, he explained, the data is captured in a form which is more computerized and produces an image that is not full size. Dr. Wheeler further stated that because the images are minified and because there are some problems with regard to resolution of the images, NIOSH does not permit ILO classification of digital images, whether or not they are minified. (E-13 at 32-33).

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| E-10 | 2/10/99 | 2/2/00 | Wheeler B/R | Focal infiltrates or fibrosis with small nodules in left apex and subapical and lateral portion upper lobes with possible few small calcified granulomata compatible with TB unknown activity, probably healed |
| E-11 | 2/10/99 | 2/2/00 | Scott B/R | Infiltrates and/or fibrosis periphery of upper lungs, increasing since 9 June 1994, compatible with TB, unknown activity |
| E-12 | 2/10/99 | | Kim B/R | Infiltrates or fibrosis in both upper lungs progressing since June 9, 1994; compatible with TB, unknown activity |
| E-10 | 3/30/99 | 2/2/00 | Wheeler B/R | Focal ill defined infiltrate or fibrosis with subtle small nodules in left apex and subapical and lateral portion upper lobes and probable few tiny calcified granulomata compatible with TB unknown activity, probably healed |
| E-11 | 3/30/99 | 2/2/00 | Scott B/R | Bilateral, predominantly peripheral, upper lung fibrosis and/or infiltrates compatible with TB, unknown activity |
| E-12 | 3/30/99 | | Kim B/R | Infiltrates or fibrosis in both upper lungs compatible with TB unknown activity |
| E-10 | 8/6/99 | 2/2/00 | Wheeler B/R | Moderate right pneumothorax probably due to recent needle aspiration biopsy of mass in RUL; moderate diffuse infiltrates in left lung some of which are from granulomatous disease and some could be pulmonary vascular congestion and hypoinflation lungs/suggest clinical correlation |
| E-11 | 8/6/99 | 2/2/00 | Scott B/R | Moderate right pneumothorax, due to recent biopsy; infiltrates and/or fibrosis as previously; hypoinflation lungs |
| E-12 | 8/6/99 | | Kim B/R | Moderate Rt pneumothorax following biopsy is seen; infiltrates or fibrosis in both lungs is seen; hypoinflated lungs |
| E-10 | 8/10/99 | 2/2/00 | Wheeler B/R | Right pneumothorax markedly decreasing since last exam and infiltrates are nearly gone from lower lungs; ill defined infiltrates or fibrosis in left apex and subapical and lateral portion upper lobes compatible with TB unknown activity, probably healed |
| E-11 | 8/10/99 | 2/2/00 | Scott B/R | Small right pneumothorax, secondary to percutaneous lung biopsy, decreasing since 6 Aug 1999; bilateral upper lung peripheral infiltrates and/or fibrosis compatible with TB, unknown activity; markings lower lungs due to hypoinflation lungs |

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|---|---|---|---|---|
| E-12 | 8/10/99 | | Kim B/R | Small residual pneumothorax, Rt; infiltrates or fibrosis in both upper lungs persist |
| E-10 | 8/13/99 | 2/2/00 | Wheeler B/R | Probable tiny residual pneumothorax upper right apex; ill defined infiltrates or fibrosis in left apex and subapical and lateral portion upper lobes compatible with TB unknown activity, probably healed |
| E-11 | 8/13/99 | 2/2/00 | Scott B/R | Tiny right apex pneumothorax decreasing since 10 Aug 1999; fibrosis and/or infiltrates lateral portion upper lungs compatible with TB, unknown activity; lower lung markings due to hypoinflation lungs |
| E-12 | 8/13/99 | | Kim B/R | Rt pneumothorax is no longer seen; infiltrates or fibrosis in both upper lungs in seen prob. granulomatous process (Tbc) unknown activity |

*Biopsy Evidence*

A CT guided needle aspiration biopsy producing a core sample of the nodule in the Claimant's right lung identified as a focal opacity in Claimant's August 2, 1999 CT scan by Dr. Ahmed was performed on August 5, 1999. (C-1). Dr. Pardasani, whose credentials are unascertainable, and Dr. Pia, who is board-certified in anatomical and clinical pathology, performed macroscopic and microscopic pathological examinations of the biopsy specimen. On macroscopic examination, they described the core biopsy as consisting of partly hemorrhagic gray fragments ranging from 0.2 to 0.7 cm. in greatest dimension. The physicians noted that the specimen was entirely embedded. On microscopic examination, Drs. Pardasani and Pia found that sections show lung tissue with fibrosis associated with deposition of black pigment, and that there are macrophages laden with black pigment. They also noted a few tiny doubly refractile bodies in the fibrotic area. Drs. Pardasani and Pia's pathological diagnosis of the biopsy of the right lung mass was "Compatible with coal workers' pneumoconiosis."

*Physicians' Opinions*

**Dr. Gaziano**

Dr. Gaziano, board-certified in internal medicine and the subspecialties of pulmonary diseases and critical care medicine, examined the Claimant on December 9, 1998. (D-13). Dr. Gaziano recorded a coal mine employment history of over forty years, lastly as a roof bolter, cutter helper, and truck driver in 1986. Claimant reported that he had never smoked. Dr. Gaziano interpreted Claimant's x-ray as positive, 2/1 Category A, large opacity, for complicated pneumoconiosis. Claimant's pulmonary function studies indicated a mild obstructive impairment and his arterial blood gases were normal. Dr. Gaziano diagnosed the Claimant with complicated coal workers' pneumoconiosis which arose out of his coal mine employment, and concluded that the Claimant had only a mild respiratory impairment. In a letter to the Claimant dated December 18, 1998, Dr.

Gaziano explained that the Claimant's x-ray shows a lesion in the upper lobe which probably represents complicated coal workers' pneumoconiosis, but that a tumor or cancer cannot be ruled out by the x-ray alone. Accordingly, Dr. Gaziano recommended that Claimant discuss further evaluation with his treating physician. (D-17).

**Dr. Dahhan**

Dr. Dahhan, board-certified in internal medicine and the subspecialty of pulmonary diseases, examined the Claimant on June 19, 1999, and reviewed additional specified medical evidence for his June 23, 1999 report. (D-30). Dr. Dahhan recorded a forty year coal mine employment history, lastly as a truck driver in 1986. Dr. Dahhan noted that the Claimant is a nonsmoker. Claimant's arterial blood gases were normal and his pulmonary function testing indicated normal respiratory mechanics. Dr. Dahhan interpreted the Claimant's x-ray as consistent with simple coal workers' pneumoconiosis, and noted that a coalescence of lesions were seen in the right upper lobe with an area of density raising the possibility of cancer vs. tuberculosis. He did not record the size of the density, but it may be inferred that the density was larger than one cm. because he affirmatively ruled out complicated pneumoconiosis. Dr. Dahhan concluded that the Claimant has simple coal workers' pneumoconiosis. He ruled out complicated coal workers' pneumoconiosis based on the various negative x-ray readings before him, normal clinical examination of the chest, and normal respiratory mechanics indicating the absence of interstitial lung disease normally seen in individuals with complicated coal workers' pneumoconiosis. From a respiratory standpoint, Dr. Dahhan opined that Claimant retains the physiological capacity to continue his previous coal mining work or a job of comparable physical demand.

Dr. Dahhan reviewed additional medical evidence for his October 22, 1999 report. (E-5). Dr. Dahhan continued to conclude that Claimant has radiological evidence consistent with Category I simple coal workers' pneumoconiosis, and that he has no evidence of complicated coal workers' pneumoconiosis or progressive massive fibrosis. He also concluded that Claimant has no functional respiratory impairment or disability, and that he retains the respiratory physiological capacity to continue his previous coal mining work or a job of comparable physical demand.

Dr. Dahhan reviewed additional specified evidence for his February 25, 2000 report. (E-14). Dr. Dahhan concluded:

> I continue to find insufficient [sic][7] radiological data to justify the diagnosis of simple coal workers' pneumoconiosis. In addition, this patient had lung tissue that was available for examination. This type of examination is the gold standard for making this diagnosis. In this case, it did reveal changes consistent with simple coal workers' pneumoconiosis as determined by Dr. Naeye with no changes

[7] Given that this is Dr. Dahhan's third report in the current claim, and he found sufficient data to justify a diagnosis of simple coal workers' pneumoconiosis in his two prior opinions and identified pathologic evidence in support of such a diagnosis in this report, this tribunal finds that Dr. Dahhan's statement was a misprint.

> indicative of complicated coal workers' pneumoconiosis or progressive massive fibrosis.

Dr. Dahhan also concluded that Claimant has no findings to indicate the presence of complicated coal workers' pneumoconiosis as demonstrated by the pathological examination of his lung, the finding of normal pulmonary function studies, and the finding of normal clinical examination of the lung.

**Dr. Fino**

Dr. Fino, board-certified in internal medicine and the subspecialty of pulmonary diseases, reviewed specified medical evidence for his September 13, 1999 report. (E-3). Based on his review of the x-rays, Dr. Fino opined that the Claimant has simple coal workers' pneumoconiosis. He further opined that, from a functional standpoint, Claimant's pulmonary system is normal and that he retains the physiologic capacity from a respiratory standpoint to perform all of the requirements of his last job. Dr. Fino found no evidence of complicated coal workers' pneumoconiosis based on his interpretations of the x-rays, the lack of distortion in Claimant's lungs such as retraction or peripheral bullae, and the lack of fibrosis or interstitial disease such as a reduction in the FVC, decreased lung volumes or an impairment in oxygen transfer. Dr. Fino identified a "coalescence of opacities," which he did not describe by size, but which may be inferred to have appeared on x-ray as larger than one cm. in diameter because he affirmatively stated that the coalescence "was not complicated coal workers' pneumoconiosis."

**Dr. Jarboe**

Dr. Jarboe, board-certified in internal medicine and the subspecialty of pulmonary diseases, reviewed specified medical evidence for his September 17, 1999 report. (E-2). Dr. Jarboe opined that there was adequate radiographic evidence to support a diagnosis of simple coal workers' pneumoconiosis; however, he did not find that the evidence supported a diagnosis of complicated pneumoconiosis. Dr. Jarboe relied on the findings of Drs. Castle, Dahhan, Scott, Wheeler, and Kim in support of the latter determination. While he was careful to acknowledge that Dr. Dahhan's identification of "a coalesce of nodules which one might confuse with complicated disease," Dr. Jarboe explained neither the significance of this finding nor how it affected his own reasoning . Dr. Jarboe concluded that there was no evidence that the Claimant has any significant respiratory impairment and that Claimant is not totally and permanently disabled to such an extent that he would be unable to do his regular coal mining work or work requiring similar effort.

Dr. Jarboe reviewed additional specified medical evidence for his March 2, 2000 report. (E-16). Dr. Jarboe opined that Claimant has coal workers' pneumoconiosis based on radiological evidence. He stated that he was unable to say within a reasonable degree of medical certainty and/or probability that he has complicated coal workers' pneumoconiosis due to conflicting x-ray and CT scan evidence. Dr. Jarboe continued to conclude that the Claimant has no significant respiratory impairment and that he is not totally and permanently disabled from a respiratory standpoint.

**Dr. Castle**

Dr. Castle, board-certified in internal medicine and the subspecialty of pulmonary diseases, reviewed specified medical evidence for his October 15, 1999 report. (E-4). Dr. Castle opined that Claimant has radiographic evidence of simple coal workers' pneumoconiosis. Dr. Castle opined that Claimant also has radiographic evidence of calcified granulomata in the upper lobes and axillary coalescence. He affirmatively stated that Claimant "did not have evidence of a large opacity." Dr. Castle stated that axillary coalescence means "that there is a movement together of a solitary small module of nodules that can be seen independently and separately. They do not constitute a large opacity." Dr. Castle also clarified that a calcified granulomata does not qualify as categorization of a large opacity because it is related to a previous infection. Accordingly, for Dr. Castle, the term "opacity" carries a diagnostic implication. Dr. Castle opined that the valid pulmonary function studies showed essentially normal pulmonary function. He also found that the arterial blood gases showed normal $pO_2$ at rest with a normal response to exercise. Dr. Castle concluded that Claimant has no respiratory impairment related to his radiographic coal workers' pneumoconiosis and that he retains the respiratory capacity to perform not only his previous coal mining employment duties, but any and all duties for which he has received training in the mining industry.

Dr. Castle was deposed on November 23, 1999. (E-9). Since his October 1999 report, Dr. Castle had reviewed additional evidence (E-9 at 10). Based on his review of all the data before him, Dr. Castle opined that Claimant has radiographic and pathological evidence of simple coal workers' pneumoconiosis (E-9 at 10). Dr. Castle disagreed with a diagnosis of complicated pneumoconiosis because the x-rays that he reviewed did not exhibit a large opacity; rather, they indicated axillary coalescence. He further stated that axillary coalescence does not constitute a large opacity, "It simply means that there are some individual nodules that are in very close proximity, but they can still be seen on an individual basis and therefore do not form a large opacity." (E-9 at 11). Dr. Castle also relied on Dr. Naeye's report in ruling out complicated pneumoconiosis, noting his findings of individual anthracotic macules which were loosely separated (E-9 at 11). Dr. Castle defined Claimant's smoking history as minimal, limited to only about ten pack-years (E-9 at 15). Upon reviewing Claimant's pulmonary function and arterial blood gas testing, Dr. Castle concluded that Claimant does not have any impairment related to his coal workers' pneumoconiosis, and that, from a purely pulmonary point of view, Claimant has the respiratory capacity to do virtually any job that he has been trained for (E-9 at 19).

**Dr. Morgan**

Dr. Morgan, board-certified in internal medicine and the subspecialty of pulmonary diseases, reviewed specified medical evidence for his October 26, 1999 report. (E-6). Dr. Morgan criticized several physicians involved in Claimant's prior claim and in the current claim. He noted that Dr. Gale "reports most if not all Black Lung claimants as having a positive film," that "Dr. Gaziano tends to be an extraordinarily liberal interpreter," and that Dr. Aycoth invariably reads all Black Lung claimants' films as positive. Dr. Morgan declared that he could not offer a definite opinion without having had the opportunity to review the chest x-rays; however, based upon the information before him, he opined that Claimant does not have coal workers' pneumoconiosis, but has some

other unrelated condition. He opined that the Claimant does not have any pulmonary or respiratory impairment, "and were it not for his age he has sufficient remaining lung function to continue to drive a truck." Dr. Morgan stated that, even if Claimant were found to have coal workers' pneumoconiosis, his opinion would not change in any way with regard to any respiratory disability since the lung function tests indicate that Claimant has no respiratory disability with the possible exception of a minor decrement in his diffusing capacity. Dr. Morgan declared that it needs to be "borne in the mind" that complicated coal workers' pneumoconiosis develops upon a background of category 2 or 3 simple coal workers' pneumoconiosis; that it is rarely, if ever, seen with category 0/1; that it may appear after the subject has ceased to work in the mines, but only when there is a large dust burden and development of category 2 or 3 simple coal workers' pneumoconiosis is present; and that it develops within three to ten years following the cessation of work involving exposure to high concentrations of dust. Dr. Morgan concluded that Claimant fulfills none of the aforementioned criteria. Dr. Morgan reviewed additional medical evidence and affirmed the opinions he expressed in his October 26, 1999 report in his November 1, 1999 report. (E-6).

Dr. Morgan reviewed additional specified evidence for his February 28, 2000 report. (E-15). Dr. Morgan commented on all the evidence before him, noting that Dr. Pathak is not a radiologist "upon whom I can rely," but that Dr. Castle is "an able chest physician whom I have known for many years going back to the time he was a Resident at the University of West Virginia Medical School when I was on the Faculty." Dr. Morgan was highly critical of Dr. Cappiello's deposition testimony. Dr. Morgan stated that a conglomerate mass is not the same thing as complicated pneumoconiosis, noting that a conglomerate mass could be an infarct, a tumor, or several other entities. Dr. Morgan elaborated on differentiating between simple and complicated pneumoconiosis on tissue biopsy:

> The appearances are completely different and sometimes complicated pneumoconiosis is filled with a grumous black liquid. Fibrotic tissue is present in complicated pneumoconiosis. The distinction is made by looking at simple and complicated CWP under the microscope and by examining the lungs at autopsy. Microscopically PMF consists of a mass of black tissue which is often adherent to the chest wall. The lesions are rubbery in consistency and are usually well defined. They bear no relationship to the macules that are adjacent to each other as described by Dr. Naeye. The massive lesion of PMF [progressive massive fibrosis] is amorphous irregular and relatively homogenous. Its centre may contain a thick walled irregular cavity filled with jet black fluid. Microscopically the conglomerate masses are composed of dense aggregates of collagenous fibrous tissue. Incorporated into the fibrous bundles are plentiful deposits of coal dust and a few scattered lymphocytes...Dr.Cappiello's description of complicated pneumoconiosis is not correct.

Dr. Morgan further criticized Dr. Cappiello's testimony, and ended his discussion with a synopsis of elements required to diagnose complicated pneumoconiosis. Dr. Morgan stated that

there must be a suitable history of exposure, at least category 2 or 3 simple pneumoconiosis, and affected lung function, usually in the form of a restrictive impairment which is only seen when the opacity is stage B or C.

Dr. Morgan concluded that the Claimant has normal lung function which goes against him having complicated coal workers' pneumoconiosis. While he stated that he was unsure as to whether he had seen the Claimant's x-rays, Dr. Morgan had "difficulty accepting the late development of obvious radiographic opacities." While Dr. Morgan could not offer a definite statement as to whether Claimant has coal workers' pneumoconiosis, he opined that Dr. Naeye's description "ensures" that Claimant has no evidence of complicated coal workers' pneumoconiosis or advanced simple coal workers' pneumoconiosis.

**Dr. Vasudevan**

In a one sentence letter to Employer's attorney dated November 1, 1999, Dr. Vasudevan, board-certified in internal, pulmonary, and critical care medicines, stated, "Based on the review of my evaluation, Mr. Blankenship did have radiographic evidence of coal workers' pneumoconiosis but no respiratory impairment from his coal workers' pneumoconiosis was not considered to be disabled to do his regular work." (E-7).

**Dr. Naeye**

Dr. Naeye, board-certified in anatomical and clinical pathology, reviewed specified medical evidence, including the surgical pathology report and one glass slide from Claimant's August 5, 1999 biopsy, for his November 15, 1999 report. (E-8). With regard to the tissue specimen from the biopsy slide, Dr. Naeye stated:

> The tissue in the biopsy specimen is lung tissue. It has mostly been replaced by 8-9 individual anthracotic macules that touch each other and are thus partially confluent. Each is 0.1-0.2 mm in width and separated from adjacent black deposits by fibrous tissue, often rather loose in its organization. The black pigment itself has a few admixed bifringent crystals of all sizes. There is absolutely nothing about these multiple adjacent anthracotic macules that bears any resemblance to complicated coal workers' pneumoconiosis or progressive massive fibrosis (PMF).

After explaining that Claimant's earlier x-rays were interpreted as negative for coal workers' pneumoconiosis, but that more recent x-rays were interpreted "in different ways raising the possibility of a neoplasm or some form of CWP being present," Dr. Naeye stated that the biopsy findings ended the uncertainty. Dr. Naeye opined that the finding of a conglomerate mass with 8-9 centers is a finding which meets the minimal criteria for the diagnosis of mild simple coal workers' pneumoconiosis. He stated that the Claimant's pulmonary function and arterial blood gas studies make it clear that Claimant has no significant abnormalities in lung function, and therefore, the mild

coal workers' pneumoconiosis is not causing any disability and is not preventing Claimant from returning to coal mining work. Dr. Naeye concluded that other factors related to Claimant's age would be a consideration in such a return to work.

**Dr. Cappiello**

Dr. Cappiello, board-certified in diagnostic radiology and a B-reader, was deposed on January 6, 2000. (C-3). With regard to the December 9, 1998 film presented to him at the deposition, Dr. Cappiello stated the following when asked to opine with regard to a possible diagnosis:

> I would have to say this is an advanced pneumoconiosis, because of all the smaller opacities and the predilection for the upper lobes. There are two densities in the right lung and the right upper lobe that I suspect, even on this, representing conglomerate masses in early stage, and possibly even in the left upper lobe.

(C-3 at 7). Dr. Cappiello also reviewed at deposition the Claimant's June 19, 1999 film, a film he had previously interpreted. He made the following observations and diagnosis:

> In my judgment, there is definitely complicated pneumoconiosis. He has got a conglomerate mass definitely in the right upper lobe that measures over a centimeter in greatest diameter. There may be a second one that I could add to that in the right upper lobe. But it's over a centimeter and qualifies as a conglomerate mass.

(C-3 at 7-8). Dr. Cappiello continued discussion of the 1998 and 1999 films:

> Q: In looking at the second film, and, of course, comparing with the first film, has there been any significant interval change, in your opinion?
>
> A: I think, in my estimation, the two densities in the right upper lobe have become more consolidating and have gotten a distinct solid appearance.
>
> Q: What is the difference, Doctor, between a conglomerate mass and complicated pneumoconiosis?
>
> A: It's the same thing. But you can see even in the '98 film that these smaller opacities are coming together and starting to coalesce. That's how the large mass forms.
>
> The little masses in a metaphorical way affect each other. They

> coalesce into a larger mass. You can see that happening between '98 and '99.
>
> Q: Is it possible that the '98 film represents an incomplete coalescence?
>
> A: I think that's a moot point. I think that --I think that I would have called it even on this film, or close to it.
>
> Q: And definitely in the '99 film?
>
> A: No doubt in my mind on the '99.

(C-3 at 7-9).

With regard to the biopsy, Dr. Cappiello opined that, because most radiologists would not pursue a nodule under a centimeter in diameter to biopsy under CT guidance, "the very fact that the biopsy was done is confirmation that this was at least a centimeter in diameter, and that it was a real mass (C-3 at 9). He also opined that pathology of the biopsy specimen is very characteristic of a conglomerate mass of pneumoconiosis, noting that the core of the mass is comprised of coal dust. However, he maintained that one could not make a distinction between simple and complicated pneumoconiosis based on the biopsy alone because it is the size of the mass that is determinative, a clear reference to the Congressional diagnostic criteria (C-3 at 10). Dr. Cappiello explained that complicated pneumoconiosis is typically in the upper lobe of the lung, and that such is this case with the Claimant. He also opined that Claimant would have a complicated mass due to coalescence in his left lung in another few years (C-3 at 15). Dr. Cappiello stated that it was not surprising that Claimant has experienced no loss in lung function because a tremendous amount of capacity must be lost before real abnormalities may be appreciated (C-3 at 16). Dr. Cappiello explained the difference between a conglomerate mass and coalescence, stating:

> If it's not a solid mass and they're just little nodules that are sticking together, and you can still identify separate nodules within this, this is what is known as a coalescent opacity. This is categorized as an "A/X." It is not entirely a conglomerate mass.
>
> A conglomerate mass you can [not] identify individual components anymore....NIOSH wrote that criteria and the ILO wrote that criteria.

(C-3 at 35-36). Dr. Cappiello also defined granulomas. He stated that a granuloma is a reaction to either an infection or a foreign body. When the body tries to get rid of it and cannot, it starts to lay down scar around it. That scar causes the appearance of opacities. (C-3 at 39). While Dr. Cappiello identified granulomas in Claimant's 1998 and 1999 x-ray films, he did not see calcifications, which would have indicated possible infection from histoplasmosis or TB (C-3 at 40).

**Dr. Wheeler**

Dr. Wheeler, board-certified in radiology and a B-reader, was deposed on February 8, 2000. (E-13). During his discussion of the ILO form for classification of pneumoconiosis, Dr. Wheeler explained that section 2C is related to large opacities, which are "nodules that have clumped together so they form a mass bigger than a centimeter in diameter and sometimes lots bigger than a centimeter in diameter." (E-13 at 22-23). He further stated that, the diagnostic category for large opacities is a potentially dangerous diagnostic category because of the risk that a large opacity may really be cancer or an active infection (E-13 at 23). Dr. Wheeler described the x-ray, CT scan, and biopsy evidence he reviewed in this claim (E-13 at 27-31). Dr. Wheeler stated that the pathological reports confirmed that the Claimant has simple silicosis (E-13 at 31).

Upon reviewing his interpretations of the CT scans and the pathology reports, which he noted did not indicate the presence of a large opacity, in spite of his interpretations of the August 2, 1999 CT scan, Dr. Wheeler opined that Claimant does not have complicated pneumoconiosis. Instead, Dr. Wheeler opined that Claimant has "some form of granulomatous disease" and "apparently pathologically had tiny macules of coal dust...separated apparently by loose, unorganized fibrosis." (E-13 at 38). Dr. Wheeler elaborated:

> He's got microscopic evidence of, apparently, simple coal workers' pneumoconiosis. He's got radiographic evidence of what looks like an asymmetrical peripheral apical disease pattern that's much more consistent with a granulomatous disease than a silicosis pattern.

(E-13 at 39). When asked whether anything reported by the pathologists would support his diagnosis of healed tuberculosis as opposed to complicated pneumoconiosis, Dr. Wheeler stated that the pathologists reported fibrosis, and fibrosis can be caused by tuberculosis, by healed pneumonia, or by anything that will stimulate fibroblasts as a reparative tissue. It did not surprise Dr. Wheeler that the Claimant had never been treated for tuberculosis, explaining that ninety percent of people with tuberculosis self-cure. (E-13 at 41-42).

## Discussion

*The Evidence Submitted with Employer's Exhibits 10 and 11*[8]

In its Brief in Support of Employer's Petition for Review, Employer asserted, among other things, that this tribunal failed to consider the multiple x-ray interpretations of Drs. Wheeler, Scott, and Kim of the February 10, 1999, March 30, 1999, and June 9, 1994 films, in addition to the interpretations by Drs. Wheeler and Scott of the October 13, 1999 film, which, in fact, are not in

[8] Employer's Exhibits 10-16 were submitted post-hearing by cover letter dated March 13, 2000. In that letter, Employer described Exhibit 10 as, "The reports of Dr. Paul S. Wheeler interpreting multiple x-ray films and two CT scans, and described Exhibit 11 as, "The reports of Dr. William W. Scott, Jr. interpreting multiple x-ray films and two CT scans."

the record. Employer also asserted that this tribunal failed to consider Dr. Scott's interpretation of the December 29, 1998, August 2, 1999, and August 5, 1999 CT scans. (Brief in Support of Employer's Petition for Review at 5). While the Board found that this tribunal did consider the interpretations by Dr. Wheeler, Scott, and Kim of the February 10, 1999, March 30, 1999, and June 9, 1994 films, which are minified digital images, it found that this tribunal neglected to consider Dr. Scott's interpretation of the December 29, 1998, August 2, 1999, and August 5, 1999 CT scans, all of which are contained within Employer's Exhibit 11. Additionally, the Board noted that the record it received did not contain any interpretations of an October 13, 1999 film, a film referred to by Employer as contained within Employer's Exhibits 10 and 11. Accordingly, because Employer's letter submitting Employer's Exhibits 10 and 11 does not specify the x-ray interpretations contained therein, the Board has directed this tribunal to identify exactly what evidence was submitted with Employer's Exhibits 10 and 11 and determine whether the interpretations of the October 13, 1999 film are a part of the record.

The following chart describes the evidence submitted with Employer's Exhibits 10 and 11. This tribunal notes that each exhibit contained the opinions of a single physician with respect to multiple pieces of evidence.

| **Exhibit** | **Interpreting Physician** | **X-ray Interpretations** | **CT Scan Interpretations** | **Minified Digital Image Interpretations** |
|---|---|---|---|---|
| E-10 | Wheeler | 2/8/94<br>12/9/98<br>6/19/99 | 12/29/98<br>8/2/99<br>8/5/99 | 6/9/94<br>2/10/99<br>3/30/99<br>8/6/99<br>8/10/99<br>8/13/99 |
| E-11 | Scott | 2/28/94 | 12/29/98<br>8/2/99<br>8/5/99 | 6/9/94<br>2/10/99<br>3/30/99<br>8/6/99<br>8/10/99<br>8/13/99 |

Neither of the above exhibits contain an interpretation of an October 13, 1999 film, and review of the record before this tribunal does not indicate the existence of a film or interpretations of such a film from that date.

*Section 718.304--The Irrebuttable Presumption of Total Disability Due to Pneumoconiosis*

Section 718.304 provides an irrebuttable presumption that the miner is totally disabled by or that the miner's death was due to pneumoconiosis if the miner is suffering or suffered from a

chronic dust disease of the lungs of an advanced degree frequently referred to as complicated pneumoconiosis. *See Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 7, 11, 96 S.Ct. 2882, 49 L.Ed.2d 752 (1976); *Eastern Associated Coal Corp. v. Director, OWCP (Scarbro)*, 220 F.3d 250, 255 (4th Cir. 2000). Section 718.304 sets out three methods by which a claimant may establish the existence of complicated pneumoconiosis: a) diagnosis by x-ray yielding one or more large opacities classified in Category A, B, or C in the International Classification of Radiographs of the Pneumoconioses by the International Labor Organization; b) diagnosis by biopsy or autopsy yielding massive lesions in the lungs, or c) when diagnosis by means other than those specified by (a) and (b) would be a condition which could reasonably be expected to yield the results described in paragraph (a) or (b) had a diagnosis been made as therein described.[9] Any diagnosis made under paragraph (c) must accord with acceptable medical procedures. §718.304(c). The Benefits Review Board has held that §718.304(a)-(c) do not provide alternative means of establishing the irrebuttable presumption of total disability due to pneumoconiosis, but rather require the administrative law judge to first evaluate the evidence in each category, and then to weigh together the categories at §718.304(a)-(c) prior to invocation. *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991) (*en banc*).

The Fourth Circuit in *Eastern Associated Coal Corp. v. Director, OWCP (Scarbro)*, 220 F.3d 250 (4th Cir. 2000), affirmed its position in *Double B Mining Inc. v. Blankenship*, 177 F.3d 240 (4th Cir. 1999) and adopted the Third Circuit's holding in *Clites v. Jones & Laughlin Steel Corp.*, 663 F.2d 14 (3d Cir. 1981), that the three prongs of §718.304 are intended to describe a single, objective condition. *Id.* at 255. Accordingly, as each prong requires a separate analysis, the Court held, "one must perform equivalency determinations to make certain that regardless of which diagnostic technique is used, the same underlying condition triggers the irrebuttable presumption." *Scarbro at 255-256; Blankenship* at 243; *see also Jones Laughlin Steel Corp.* at 16.

In *Blankenship*, the Fourth Circuit elaborated the required equivalency determination, stating:

> Because prong (A) sets up an entirely objective scientific standard, it provides the mechanism for determining equivalencies under prong (B) or prong (C). In prong (A), Congress mandated that the condition that triggers the irrebuttable presumption is one that creates, on an x-ray, at least one opacity greater than one centimeter in diameter. When that condition is diagnosed by biopsy rather than x-ray, it must therefore be determined whether the biopsy results show a condition that would produce opacities of greater than one centimeter in diameter on an x-ray. That is to say, "massive lesions," as described in prong (B), are lesions that when x-rayed, show as opacities greater than one centimeter in diameter.

[9] A chronic dust disease of the lungs which would be classified in Category A, B, or C would yield one or more large opacities greater than 1 centimeter in diameter. §718.304(a)

*Blankenship* at 243. The Court recognized that it might be necessary for an ALJ to make a separate equivalency determination each time a miner presents evidence of massive lesions diagnosed by biopsy. *Id.* at 244. The Court stated that "the x-ray evidence can lose force only if other evidence affirmatively shows that the opacities are not there or are not what they appear to be perhaps because of an intervening pathology, some technical problem with the equipment used, or incompetence of the reader." *Scarbro* at 256.

Since the record of this claim contains evidence under each of the three prongs under §718.304, in order to establish that he has complicated pneumoconiosis, Claimant must establish that he has a chronic dust disease of the lungs which on x-ray yields one or more large opacities greater than 1.0 cm. in diameter, on biopsy yields a massive lesion(s) equivalent to in size to its corresponding x-ray opacity, and, by any other acceptable medically diagnostic procedure, yields evidence confirming that the condition or process which gave rise to the aforementioned lesion(s) is, in fact, a chronic dust disease of the lungs.

In its prior decision, this tribunal found that, by 1999, the coalescence of nodules in the Claimant's right upper lobe had developed into a solid mass measuring at least 1.0 cm. in diameter, which on needle biopsy was confirmed to contain nodules of coal workers' pneumoconiosis. Accordingly, this tribunal concluded that the Claimant established that he has complicated coal workers' pneumoconiosis and was entitled to the invocation of the irrebuttable presumption of total disability due to pneumoconiosis. (Decision and Order - Awarding Benefits, slip. op. at 18-20). On remand, the Board directed this tribunal to reconsider all evidence of record and include within its analysis consideration of the physicians' credentials. The Board also directed this tribunal to reweigh each medical opinion without considering the physician's findings as to the existence of a pulmonary impairment, since evidence of disability is not probative of the issue of complicated pneumoconiosis under the statute or regulations.[10] §718.304. *See Trent v. Director, OWCP*, 11 BLR 1-26, 1-28 (1987).

*X-ray Evidence under Prong (a) of §718.304*

The record contains evidence of twelve x-rays interpreted by sixteen physicians for a total of thirty-one interpretations. Of those sixteen physicians, six are B-readers, and seven are dually qualified board-certified radiologists and B-readers.[11] Prong (a) of §718.304 dictates that the presumption is established by x-rays yielding one or more large opacities (greater than 1.0 centimeter in diameter) that would be classified in Category A, B or C in the ILO-U/C International

[10]It is noteworthy that several physicians of record considered the absence of impairment as proof of nonexistence of complicated pneumoconiosis.

[11]The remaining three physicians, Drs. Groten, Olson, and Rahman, reviewed six films that appear to have become minified digital images. Those physicians' credentials could not be ascertained. However, because they read the films in order to chart Claimant's progress and the development of a pneumothorax subsequent to his August 5, 1999 needle aspiration biopsy, and did not provide opinions with regard to the Claimant's pneumoconiosis, their readings and credentials are not pertinent to the issue of complicated pneumoconiosis.

Classification of Radiographs of the Pneumoconioses. Of the six B-readers and seven dually qualified physicians, only three interpreted the films as negative for pneumoconiosis. Drs. Wheeler, Scott, and Kim, all dually qualified board-certified radiologists and B-readers, each interpreted the February 28, 1994, the December 9, 1998, and the June 19, 1999 films, and found that none evidenced the presence of even simple coal workers' pneumoconiosis, the presence of which has been previously established and stipulated to by the parties (D-25, 26, 31; E-1, 10, 11, 12). In its prior decision, this tribunal accorded less weight to the readings of Drs. Wheeler, Scott, and Kim because they were based on an incorrect underlying premise--the absence of simple coal workers' pneumoconiosis (Decision and Order--Awarding Benefits , slip. op. at 18). The Board found no error with this determination, finding that it was reasonable for this tribunal to question the reliability of the physicians' readings with regard to the issue of complicated pneumoconiosis. Accordingly, this tribunal adopts and reaffirms its prior attribution of less weight to the x-ray interpretations of Drs. Wheeler, Scott, and Kim.

Three of the remaining four dually qualified physicians, Drs. Ahmed, McFarland, and Cappiello, diagnosed changes consistent with complicated pneumoconiosis under prong (a). Dr. Ahmed interpreted the June 9, 1994, and February 10, 1999 films (C-1). While he did not utilize the ILO system when interpreting the Claimant's films, he provided written reports documenting the progression of Claimant's pneumoconiosis. In 1994, Dr. Ahmed noted that the Claimant had underlying pneumoconiosis. By February 1999, Dr. Ahmed found changes consistent with complicated pneumoconiosis where pneumoconiosis was seen before. Dr. McFarland interpreted the December 9, 1998 film as positive for complicated pneumoconiosis, Category A, on a background of category 2/3 pneumoconiosis (C-1). Dr. Cappiello interpreted the June 19, 1999 film as positive for complicated pneumoconiosis with large Category A and small opacities 2/2 (C-2). The remaining dually qualified physician, Dr. Miller, interpreted the October 14, 1998 film as consistent with pneumoconiosis with slight worsening compared to 1994 (C-1). His opinion that the Claimant's pneumoconiosis had progressed in the interim between 1994 and 1998 corroborates Dr. Ahmed's findings with respect to the progression of the disease. Accordingly, the preponderance of the x-ray interpretations provided by credible dually qualified physicians establish that the Claimant's pneumoconiosis progressed since 1994, and is now properly categorized as complicated pneumoconiosis based on the x-ray evidence.

All six B-readers interpreted the films as positive, at least, for simple pneumoconiosis, ranging in degree from category 1/1 to category 2/3 (C-1; D-16, 24, 30; E-3, 4). Dr. Gaziano diagnosed complicated pneumoconiosis, Category A, on a background of 2/1 pneumoconiosis (D-16). Dr. Gaziano noted that the lesion was in the upper lobe and that it was necessary to rule out cancer. Dr. Aycoth, who interpreted the February 28, 1994 film as positive for pneumoconiosis in 1994, diagnosed changes of complicated pneumoconiosis upon review of the March 30, 1999 film on that same date (C-1). Drs. Castle, Fino, Dahhan, and Hippensteel, did not diagnose complicated pneumoconiosis. However, all four found coalescence. Dr. Fino opined that the coalescence could be related to tuberculosis. Dr. Dahhan noted an area of density within the coalescence for which he did not record a size, but which must have been larger than 1.0 cm. in diameter because he affirmatively ruled out complicated pneumoconiosis (D-30). Drs. Dahhan, Castle, and Hippensteel additionally noted upper lobe calcifications questionably related to tuberculosis or granulomatous

disease. (D-24, 30; E-3, 4). Accordingly, the B-readers' interpretations indicate that Claimant has moderate to severe pneumoconiosis with changes that could be attributable to either progressing simple pneumoconiosis, complicated pneumoconiosis, some form of granulomatous disease, or cancer. As indicated by Drs. Gaziano and Fino, who are both pulmonary specialists, a clinical correlation would aid in the resolution of the Claimant's x-rays (D-16; E-3).

This tribunal finds that the preponderance of the x-ray evidence establishes that the Claimant has complicated pneumoconiosis on a background of moderate to severe simple pneumoconiosis. All of the most credible dually qualified physicians identified a radiographic progression in Claimant's pneumoconiosis during a four to five year interim such that it now forms opacities more appropriately categorized as complicated pneumoconiosis. Two explicitly found Category A opacities under the ILO classification system; Dr. Ahmed found complicated pneumoconiosis; and Dr. Miller noted progression of the pneumoconiosis. Two B-readers provided corroborative interpretations, in that Dr. Gaziano noted a Category A opacity needing further assessment as possible cancer, and Dr. Aycoth explicitly diagnosed complicated pneumoconiosis. The remaining four B-readers, Drs. Castle, Fino, Dahhan, and Hippensteel, described coalescence and calcification of granulomas, abnormalities not inconsistent with a finding of 1.0 cm. opacities, and which could be manifestations of complicated pneumoconiosis if clinically correlated. Therefore, because the record contains pathological evidence derived from Claimant's x-ray abnormalities, the findings of these four B-readers are not incompatible with an ultimate finding of complicated pneumoconiosis.

*Biopsy and/or Autopsy Evidence under Prong (b)*

A CT guided fine needle biopsy was undertaken of the mass in Claimant's right upper lung lobe on August 5, 1999 at Princeton Community Hospital**.** (C-1). The biopsy yielded a core sample of the mass verifying its composition to be deposits of black pigments and macules diagnostic of coal workers' pneumoconiosis. The core sample does not establish the size of the mass from which it came and neither negates nor supports a finding that the mass is equivalent to 1.0 cm. mass on x-ray. Other evidence of record establishes that the mass is large enough to appear as a greater than 1.0 cm. mass on x-ray, thereby meeting the equivalency requirement under *Scarbro* and §781.304.

The biopsy was performed subsequent to an August 2, 1999 CT scan ordered by Dr. Jabour, board-certified in internal medicine and the subspecialty of pulmonary diseases.[12] Dr. Ahmed, a dually qualified board-certified radiologist and B-reader, interpreted that CT scan and compared it to a July 14, 1999 chest x-ray. He found that it evidenced a progression of the multiple nodules in the upper half of both lung fields, a focal opacity in the right suprahilar region, and multiple larger

[12]The credentials of Dr. Jabour are not of record. However, this tribunal takes judicial notice that his relevant qualifications are disclosed on the worldwide web, American Board of Medical Specialties, Who's Certified Results, at http://www.abms.org. *See Maddaleni v. Pittsburgh & Midway Coal Mining Co.*, 14 BLR 1-135 (1990).

than 1.0 cm. size lymph nodes in the superior mediastinum. Dr. Ahmed recommended biopsy under CT scan for further evaluation. (C-1). The report of the CT scan guided biopsy, dated August 5, 1999, indicates that it too was ordered by Dr. Jabour and that it was required for the diagnosis of a right lung mass, presumably the one described by Dr. Ahmed three days prior. Though neither Dr. Ahmed, Dr. Jabour, nor Dr. Groten, the surgeon who performed the biopsy, described the right lung mass by its size, the preponderance of the evidence indicates that the notable mass in Claimant's right upper lobe appears as a greater than 1.0 cm. mass on x-ray in the Claimant's right upper lobe, as evidenced by radiographic findings of Category A complicated pneumoconiosis and other abnormalities in that lung region, and additional interpretations of the August 2, 1999 CT scan by Drs. Wheeler and Kim, dually qualified board-certified radiologists and B-readers. Dr. Kim identified a 4 x 3 cm. nodule in the right upper lobe ; Dr. Wheeler identified a 4 cm. mass in the right upper lung. (D-15, 16, 30, 31; C-1, 2; E-3, 4, 10,12). Additionally, Dr. Cappiello, board-certified in diagnostic radiology and a B-reader, testified that because most radiologists would not biopsy with CT guidance a nodule that was less than 1.0 cm. in diameter, the fact that such a procedure was performed on the Claimant "is confirmation" that the mass is at least 1.0 cm. in diameter (C-3 at 9). Because the preponderance of the x-ray evidence, CT scan interpretations by dually qualified physicians, and the reasoned opinion of Dr. Cappiello persuasively indicate that the biopsied mass in the Claimant's right upper lung lobe presents as a radiographic opacity that is at least 1.0 cm. in diameter, this tribunal finds that the size of the mass in question is equivalent to at least a 1.0 cm. mass on x-ray.

More significant than the mass's size equivalency is the biopsied sample's confirmation that the mass is a manifestation of a chronic dust disease of the lungs. The microscopic examination of the core sample showed lung tissue with fibrosis associated with disposition of black pigment, macrophages laden with black pigment, and "doubly refractile bodies." Dr. Pardasani, whose credentials could not be ascertained, and Dr. Pia, a board-certified clinical and anatomical pathologist, who provided the pathological examination of the biopsy at Princeton Community Hospital, diagnosed coal workers' pneumoconiosis. (C-1). Dr. Naeye, who is also board-certified in anatomic and clinical pathology, reviewed Drs. Pardasani and Pia's report and the glass slide containing the core sample from which he described as one of the largest of the lesions noted in Claimant's x-rays (E-8). Dr. Naeye concurred that the lung tissue specimen had "mostly been replaced by 8-9 individual anthracotic macules that touch each other and are thus partially confluent," and that it put an "end to the uncertainty" with regard to whether the recent x-ray evidence revealed either neoplasm or coal workers' pneumoconiosis. Dr. Naeye concluded that the lung tissue represented mild, simple coal workers' pneumoconiosis, and, in a clear reference to medical rather than the applicable legal criteria, opined that nothing about the macules, which he then described as adjacent rather than partially confluent, bears any resemblance to complicated coal workers pneumoconiosis or progressive massive fibrosis. (E-8). Accordingly, the biopsy evidence precludes a finding that the mass in the Claimant's right upper lung lobe is cancerous, neoplastic, or granulomatous in origin. Rather, the evidence establishes that the mass, which is visible on x-ray as an opacity at least 1.0 cm. in diameter, is comprised of pneumoconiotic macules and black fibrous tissue characteristic of coal workers' pneumoconiosis, a chronic dust disease of the lungs.

*Diagnosis by Other Equivalent Means under Prong (c)*

Under prong (c), the irrebuttable presumption may be invoked where the miner suffered from a chronic lung disease which, when diagnosed by means other than those described in prongs (a) and (b) would be a condition which could reasonably be expected to yield the massive lesions described in prongs (a) and (b). The language indicates that the diagnosis need not actually identify the existence of massive lesions. Instead, it is, at least, the disease process behind the formation of massive lesions which must be diagnosed, that disease process being complicated pneumoconiosis as defined by the statute and regulations. S*ee Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 7, 11 (1996); *Eastern Associated Coal Corp. v. Director, OWCP (Scarbro)*, 220 F.3d 250, 255 (4th Cir. 2000). Accordingly, because it is clear that massive lesions must exist under §718.304(a) and (b), and prong (c) must not be to the contrary, prong (c) encompasses diagnostic evidence corroborating the disease process established under prongs (a) and/or (b). At a minimum, the evidence under prong (c) is corroborative of evidence under prongs (a) and (b) if it does not refute that the massive lesions established thereunder are what they appear to be. *See Scarbro* at 256. The CT scan evidence and the reasoned medical opinions fall under prong (c). *See Melnick v. Consolidation Coal Co.*, 16 BLR. 1-31 (1991) (*en banc*).[13]

The x-ray and pathologic evidence establishes that Claimant has at least one greater than 1.0 cm mass in his lungs which is comprised of pneumoconiotic macules and black pigmented fibrosis. The evidence under prong (c) does not refute that the disease process responsible for the formation of that mass qualifies as complicated pneumoconiosis under the Act. In fact, the evidence under prong (c) affirmatively establishes that the massive lesion in Claimant's right upper lung qualifies as complicated pneumoconiosis, entitling the Claimant to invocation of the irrebuttable presumption.

The mixed CT scan evidence suggested the need for clinical correlation of the Claimant's right upper lung mass and fibrosis, but did not conclusively establish the existence or nonexistence of complicated pneumoconiosis. The interpretations of Drs. Wheeler, Scott, and Kim are not credible because they did not diagnose pneumoconiosis at all, and because they attributed Clamant's fibrosis and documented lung mass to tuberculosis or a granulomatous process eliminated by the biopsy; the biopsy evidence unequivocally established that the mass in Claimant's right upper lung was not a result of granulomatous disease (E-10, 11, 12). The interpretations of Drs. Ahmed and Cappiello, who is also a dually qualified board-certified radiologist and B-reader, are credible, but neither physician affirmatively ruled in or out the existence of complicated pneumoconiosis based

[13]The minified digital images were separately considered by this tribunal. However, because they are neither x-rays deemed subject to ILO classification nor CT scans, which are properly considered under prong (c), and because Dr. Wheeler testified that their resolution is problematic, this tribunal finds that the minified digital images are not deemed to be reliable evidence of a condition expected to yield the massive lesions described in prongs (a) and (b). Moreover, because the minified digital images were only interpreted by Drs. Kim, Scott, and Wheeler, all of whom interpreted the Claimant's x-rays and minified digital images as negative for pneumoconiosis inconsistent with the Claimant's previously established simple coal workers' pneumoconiosis, and because the Board has upheld this tribunal's finding that the opinions of Drs. Kim, Scott, and Wheeler with regard to the pertinent x-ray interpretations are entitled to less weight, this tribunal similarly would accord little weight to the minified digital image interpretations under this prong, had they been included.

on CT scan alone. Instead, their interpretations lead to the Claimant's biopsy (C-1, 2). Dr. Pathak's opinion supports a finding of complicated pneumoconiosis (C-1). However, because he has not been shown to be a board-certified radiologist, and in light of the mixed CT scan evidence, Dr. Pathak's opinion is not dispositive of this issue.

The other evidence of record under prong (c) includes the medical opinions of ten physicians. The primary disagreement among these physicians is twofold. First, the several physicians either rule in or out complicated pneumoconiosis based on differing criteria, with some utilizing the congressionally defined or statutory and regulatory definition, and others relying upon a purely medical or pathological definition. Second, stemming from the inconsistent use of criteria among the physicians is a disagreement with regard to the process taking place in the Claimant's lungs and whether such process is consistent with a finding of complicated pneumoconiosis. The Fourth Circuit's analysis of the irrebuttable presumption of causation as created by §921(c)(3) of the Act in *Eastern Associated Coal Corp. v. Director, OWCP (Scarbro)*, 220 F.3d 250 (4th Cir. 2000) provides guidance for resolving the conflict among the opposing opinions in this case.

In *Scarbro*, the Court noted that Section 921(c)(3) does not refer to the triggering condition "complicated pneumoconiosis," nor does it refer to a medical condition that physicians independently have called complicated pneumoconiosis. Rather, the Court explained, the presumption is triggered by a congressionally defined condition, the existence of which may be established by three methods that would not necessarily be useful as diagnostic guidelines in a clinical setting. *Scarbro* at 257 ("In short, the statute betrays no intent to incorporate a purely medical definition."). Moreover, the Court emphasized, that, to the extent that there is a divergence between the medical and legal standards for complicated pneumoconiosis, the standard established by Congress must be applied. *Id.* Accordingly, though the Board has advised this tribunal not to consider physicians' findings with regard to the existence of a pulmonary impairment upon re-evaluation of the medical opinions, where a physician has ruled out complicated pneumoconiosis based on the absence of a pulmonary impairment, this factor is obviously material to the physician's credibility. Such reasoning by a physician clearly indicates consideration of clinical criteria beyond the three prong methodology established by the Act, and, therefore, cannot be ignored.

Seven equally qualified board-certified pulmonary specialists, Drs. Gaziano, Dahhan, Fino, Jarboe, Castle, Vasudevan, and Morgan provided opinions with regard to whether the Claimant has complicated pneumoconiosis. Only Dr. Gaziano, who examined the Claimant, opined explicitly that Claimant has complicated pneumoconiosis. Dr. Gaziano based his finding on Claimant's December 9, 1998 x-ray film which evidenced right upper lobe lesion compatible with Category A complicated pneumoconiosis. (D-13, 16). While Dr. Gaziano speculated that the lesion might represent cancer or a tumor, the pathologic evidence of record, which was not before Dr. Gaziano, affirmed that the lesion is neither cancerous nor neoplastic. Accordingly, Dr. Gaziano's opinion based on the evidence before him and substantiated by the preponderance of the radiographic and pathologic evidence favors a finding of complicated pneumoconiosis.

The remaining six physicians all opined that Claimant does not have complicated pneumoconiosis. However, Dr. Vasudevan's one sentence opinion is entitled to little weight

because it is undocumented, it does not indicate that he considered the degree of Claimant's pneumoconiosis, and it is entirely based on his own past evaluation of the Claimant which the record indicates occurred on May 18, 1988, many years prior to the documented progression of Claimant's pneumoconiosis (D-32; E-7). Dr. Jarboe, while offering a reasoned opinion, was unable to reach a conclusion as to whether or not the Claimant has complicated pneumoconiosis due to the conflicting nature of the objective evidence (E-16). Therefore, Dr. Jarboe's equivocal opinion is not probative of the existence of complicated pneumoconiosis, but, significantly, does not rule it out.

Dr. Morgan's opinion, which is dependent upon acceptance only of a narrow medical definition of complicated pneumoconiosis, does not evidence that Dr. Morgan reached his own independent conclusion, and is not well-reasoned. Therefore, it is entitled to little weight. Rather than examining the objective evidence of record and forming his own opinion based thereon, Dr. Morgan apparently relied exclusively on evidence produced by physicians which he personally finds "able" and "reliable" based entirely on his personal dealings with them. By sorting the evidence in this manner, Dr. Morgan essentially disregarded the radiographic evidence of Claimant's pneumoconiosis and the original pathology report of Claimant's biopsy. Accordingly, Dr. Morgan was unable to opine with regard to whether the Claimant has even simple pneumoconiosis, though, he expressed his reliance on Dr. Naeye's pathological description of Claimant's biopsy in which he ruled out complicated and advanced simple coal workers' pneumoconiosis. (E-6, 15).

Additionally, Dr. Morgan declared that Claimant met none of the criteria that he associates with a diagnosis of complicated pneumoconiosis. (E-15). While Claimant need not establish that his disease fits Dr. Morgan's definition of complicated pneumoconiosis, which is clinical as opposed to statutory, the objective evidence of record suggests that Claimant's disease in fact meets some of Dr. Morgan's criteria: Claimant has both a history of exposure to coal mine dust and category 2 simple pneumoconiosis; his biopsy tissue contains fibrotic tissue with black pigment; and Claimant's conglomerate lesion developed three to ten years following cessation of work involving exposure to high concentrations of dust. (C-1, 2; D-15, 16, 24; E-4, 6, 8, 15). Thus, even within his own criteria, Dr. Morgan failed to interpret the objective medical evidence of record within a reasoned medical opinion.

Drs. Fino, Castle, and Dahhan ruled out complicated pneumoconiosis based primarily on their own interpretations of the x-rays and the absence of the interstitial lung disease or respiratory impairment normally associated with clinical complicated pneumoconiosis because of Claimant's normal respiratory mechanics. (D-30; E-3, 5, 9, 14). Since their opinions are only based in part on their findings that certain objective evidence is inconsistent with the medical criteria generally associated with complicated pneumoconiosis, the probative value of Drs. Fino, Castle, and Dahhan's opinion is not inconsequential. Drs. Fino, Castle and Dahhan all opined that Claimant's right upper lung contained an area of coalescing nodules of simple pneumoconiosis which they concluded did not qualify as complicated pneumoconiosis. Drs. Castle and Dahhan both noted the presence of an "area of density" which they opined was granulomatous or possibly cancer vs. tuberculosis, respectively. (D-30; E-3, 4, 9 at 11). However, none of the three physicians is a board-certified radiologist, and therefore, since their evaluations were based upon x-ray interpretations,the reliability of their opinions is affected by consideration of the remaining medical opinions provided

by two radiologists and a pathologist.

Drs. Wheeler and Cappiello, both dually qualified board-certified radiologists and B-readers, were in apparent agreement that complicated pneumoconiosis, as described in the ILO system and therefore under the statutory/regulatory definition, is the result of a process in which small opacities of pneumoconiosis have coalesced or merged into a conglomerate mass which is larger than one centimeter in diameter (C-3 at 7-8, 35-36; E-13 at 22-23). Dr. Cappiello explained the difference between coalescence and conglomeration as one of degree. Dr. Wheeler did not address this issue explicitly. With a coalescent opacity, according to Dr. Cappiello, the individual opacities are still identifiable as separate nodules. However, with a conglomerate mass, the individual components are no longer identifiable (C-3 at 35-36). Dr. Cappiello opined that Claimant's complicated pneumoconiosis is a conglomerate which resulted from coalescing opacities and that the same process is currently occurring in Claimant's left lung such that it too will have a mass of complicated pneumoconiosis in another few years. (C-3 at 7-8, 15).

On the other hand, Dr. Wheeler did not opine that the opacity in Claimant's right lung is a conglomerate of complicated pneumoconiosis. Dr. Wheeler opined that the small masses in Claimant's lungs were granulomatous and that the four centimeter mass in the Claimant's right upper lung which he described upon review of Claimant's August 2 and August 5, 1999 CT scans was a conglomerate of tuberculosis as opposed to pneumoconiosis. (E-10, 13 at 35-39). In fact, Dr. Wheeler never identified opacities of pneumoconiosis in any of his x-ray and CT scan readings and only dubiously conceded to a diagnosis of simple pneumoconiosis upon review of the pathologic evidence, noting that Claimant "apparently pathologically has tiny macules of coal dust ." (E-13 at 38). Moreover, when asked to identify pathologic evidence in support of his diagnosis of conglomerate tuberculosis rather than complicated pneumoconiosis, Dr. Wheeler noted the pathologists' findings of fibrosis. However, he conceded that fibrosis is a rather generic byproduct of any disease which stimulated the formation of reparative tissue by fibroblasts. (E-13 at 41-42).[14] Of the two opinions, Dr. Cappiello's is more persuasive because it is well reasoned and substantiated by the objective evidence of record, which indicates that Claimant has both simple pneumoconiosis and a large mass in his right upper lung which is pneumoconiotic and coal dust related in character, and which was found not to be tuberculosis or any other granulomatous disease on biopsy. Moreover, this tribunal notes that Dr. Wheeler recognized the four centimeter mass as an "opacity," and therefore, by implication, the fact that he thought it was a manifestation of tuberculosis, does not affect its character as an "opacity" under the Act and regulations. Rather, the disproof of his diagnosis by biopsy evidence further supports Dr. Cappiello's findings.

Dr. Naeye's medical opinion was relied upon by Drs. Castle and Dahhan in support of their contention that the Claimant's right upper lung mass is the result of incomplete coalescence into a conglomerate mass. Dr. Naeye, board-certified in anatomical and clinical pathology, reviewed evidence of record including the biopsied core tissue sample. Dr. Naeye described the lung tissue sample twice in his one page report. First, Dr. Naeye stated that the lung tissue had mostly been replaced by 8-9 individual anthracotic macules that are "partially confluent." He stated that each

[14]Dr. Morgan identified fibrosis as a characteristic of clinical complicated pneumoconiosis. (E-15).

macule was 0.1 to 0.2 mm. in width and separated from adjacent black deposits of fibrous tissue containing black pigment. He found nothing about these macules consistent with what was obviously his clinical definition of complicated pneumoconiosis or progressive massive fibrosis, though he did not describe the criteria he used to rule out complicated pneumoconiosis. Then, Dr. Naeye described the tissue as containing multiple anthracotic macules which touch each other, "forming a conglomerate mass with 8-9 centers," a finding which he noted "meets the minimal criteria for the diagnosis of mild, simple coal workers' pneumoconiosis." Furthermore, Dr. Naeye stated that his pathological findings confirmed that the mass from which the tissue was taken is not a neoplasm but is a form of coal workers' pneumoconiosis (E-8). Though Dr. Naeye's consistent referral to 8-9 individual macules suggests that Claimant's mass, on the microscopic level, is really a coalescence of macules which have yet to complete their formation of a singular conglomerate, his description of the tissue sample and determination that it does not represent complicated pneumoconiosis, nevertheless, only rules out a finding that the Claimant does not have clinical complicated pneumoconiosis as described by certain of the doctors. Dr. Naeye's description of merging pneumoconiosis macules is consistent with the statutory criteria under prong (c) because it describes a chronic dust disease of the lungs which, as outlined by Drs. Wheeler and Cappiello, could reasonably be expected to yield the massive lesions described in prongs (a) and (b).

Dr. Naeye's description of "confluent" macules that also formed a "conglomerate mass" is a description of statutory complicated pneumoconiosis to the extent that it would appear as a large opacity on x-ray. According to the Online Medical Dictionary[15], "confluent" means "Joining; running together...denoting a disease characterized by lesions which are not discrete, or distinct one from the other." "Conglomerate" means "Composed of several parts aggregated into one mass." Accordingly, though he described the macules as distinct entities, he also described them as being partially joined either by touching directly or through fibrous tissue. While Dr. Naeye stated that his findings meet the minimal criteria for a diagnosis of minimal simple coal workers' pneumoconiosis, he did not further explain the significance of the macules running together into a confluence or a conglomerate and whether, over time, they would eventually be indistinguishable on the microscopic level.

In any event, there is no evidence that these distinctions are now evident in the resulting lesion which presents on x-ray as a large opacity. Under prong (c) it is the disease process behind the formation of massive lesions which must be diagnosed, that disease process being complicated pneumoconiosis as perceived and defined by Congress. S*ee Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 7, 11, 96 S.Ct. 2882, 49 L.Ed.2d 752 (1976); *Eastern Associated Coal Corp. v. Director, OWCP (Scarbro)*, 220 F.3d 250, 255 (4th Cir. 2000). Here, the pathological evidence described by Dr. Naeye in his medical opinion establishes that Claimant's pneumoconiosis has

[15] The Online Medical Dictionary may be found at http://cancerweb.ncl.ac.uk/omd/. Webster's Ninth New Collegiate Dictionary (1986) similarly defines "confluent" as "1: flowing or coming together; also: run together (~ pustules) 2: characterized by confluent lesions (~ smallpox)." That source defines "conglomerate" as "made up of parts from various sources or of various kinds (an ethically ~ culture)." The Court in *Scarbro* endorsed reliance on dictionary definitions to construe words where no precise statutory or medical definition is provided, though it cautioned fact finders to remain sensitive to conflicting meanings. *Scarbro* at 257, 259.

begun to form conglomerates at least within the confines of a larger mass. This is not inconsistent with the formation of the large opacity seen on x-ray, and is consistent with the process described by both Drs. Cappiello and Wheeler as the formation of complicated pneumoconiosis recognized under prong (a). Accordingly, because Claimant's individual macules of pneumoconiosis have begun the conglomeration process on the microscopic level, Dr. Naeye's report is equivalent to a finding of statutorily defined pneumoconiosis, a finding corroborated by the well reasoned opinions of Drs. Gaziano and Cappiello. Therefore, the opinions of Drs. Castle and Dahhan, who relied on Dr. Naeye's pathological expertise to reconcile their findings of coalescence, do not weigh against a finding of statutory complicated pneumoconiosis. And, although Dr. Fino did not review any pathological evidence, his opinion that the Claimant's lungs exhibit only coalescence also does not negate a finding of complicated pneumoconiosis.

*Conclusion under §718.304*

Since the preponderance of the evidence under the three prongs of §718.304 considered together establishes the existence of complicated pneumoconiosis, and considered separately are probative thereof and not inconsistent therewith, this tribunal finds that the Claimant is entitled to invoke the irrebuttable presumption of §718.304. The preponderance of the radiographic evidence under prong (a) establishes complicated pneumoconiosis Category A with a large mass in Claimant's right upper lung. The biopsy evidence under prong (b) demonstrates that the mass is comprised of coal workers' pneumoconiosis, and not other types of lesions, thereby establishing that the mass on x-ray is what it appears to be. Other evidence considered related to the actual biopsy evidence further establishes that the mass is large enough to produce a greater than 1.0 cm. opacity on x-ray, permitting the appropriate equivalency determination. *See Scarbro* at 256. The remaining evidence under prong (c) further establishes that the mass represents a condition associated with statutory complicated pneumoconiosis. The entirety of the evidence, therefore, establishes that Claimant's pneumoconiosis progressed, and continues to progress, from simple to complicated pneumoconiosis over at least the last eight years.

Date of Onset

Benefits are payable to a miner who is entitled beginning with the month of onset of total disability due to pneumoconiosis arising out of coal mine employment. Where the evidence does not establish the month of onset, benefits shall be payable to such miner beginning with the month during which the claim was filed. §725.503. Claimant became totally disabled due to pneumoconiosis on the first date upon which he became entitled to invocation of the irrebuttable presumption of §718.304. The Claimant's right lung mass was first identified and attributed to complicated pneumoconiosis on December 9, 1998 by Dr. Gaziano. (D-16). Since the evidentiary record establishes that this mass is complicated pneumoconiosis, this tribunal finds that Claimant became entitled to invocation of the irrebuttable presumption on December 9, 1998, and that the date of onset for benefits is December 1, 1998.

Attorney's Fee

An attorney's fee is approvable in accordance with 20 C.F.R. §§725.366 and 725.367. Application for such approval, with service upon Claimant and all other parties, should be filed within thirty (30) days of the date of this decision. Parties may file objections within ten (10) days following receipt of such an application. The Act prohibits charging a fee without prior approval pursuant to these applicable regulations.

**ORDER**

The claim of Dennis O. Blankenship for benefits under the Act is granted. Respondent Cannelton Industries, Inc. shall pay black lung benefits to the Claimant Dennis as calculated by the Director, OWCP, commencing as of December 1, 1998.

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EDWARD TERHUNE MILLER
Administrative Law Judge

Washington, D.C.

**NOTICE OF APPEAL RIGHTS**: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of this Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20001.